lost its offensive odor. In the course of the treatment, air was on coughing expelled through the opening. There was progressive improvement in both the local and the general condition, until recovery ensued.

SURGERY.

UNDER THE CHARGE OF

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TOTAL EXTIRPATION OF POPLITEAL ANEURISMS.

MEINHARD SCHMIDT advocates, in the *Archiv für klinische Chirurgie*, 1893, Bd. xxiv., Heft 4, the extirpation of popliteal aneurisms. The aneurism is to be removed exactly as if it were a tumor. The advantages over the Antyllean method, which is the next most radical, is that no unnecessary part of the diseased vessel is left behind, which might become the seat of suppurative processes.

In the forearms and legs, where there are two main vessels of supply, and the chance for a good collateral circulation is very favorable, the radical method is the operation of choice.

The author details a case in which he excised a popliteal aneurism from each leg of a patient. The most tedious part of the operation, in nearly every case, is the separation of the vein from the artery. The integrity of the vein should be maintained if it is possible.

The author prefers packing and secondary sutures, to be tied in forty-eight hours.

In the twelve cases collected by the author (including his own), the results have been very favorable. Gangrene did not occur; even an accidental cut of the vein had no unfavorable influence upon the establishment of collateral circulation.

ON THE TREATMENT OF SPINAL ABSCESS.

WATSON CHEYNE, in an address before the British Medical Association (*British Medical Journal*, 1892, No. 1670), briefly reviews the older methods of operating, and speaks in considerable detail of the modern antiseptic methods. It is well known that the opening of these abscesses in the pre-antiseptic period was almost surely followed by profuse suppuration, rapid wasting of the patient, and frequently death. As a consequence, at that time surgeons unanimously advised against operation.

Lannelongue asserts, basing his conclusion on post-mortem evidences, that even in those cases of vertebral disease without visible abscess, a focus of caseation is usually present.

Twenty or thirty years ago, therefore, the best method of operating in cases of spinal abscess was aspiration by means of a trocar. The author, in 1888, collected fifty-eight cases which had been thus operated upon either by Sir Joseph Lister or himself. Of these, forty-nine remained aseptic throughout. Thirty-eight, or 77½ per cent., were cured at the time that the statistics were compiled. These were advancing toward cure, and five had died of tuberculosis or other causes than the abscess.

The treatment by drainage has, however, certain disadvantages. The wound requires a long period for healing; the average length of time in the cases quoted was between eight and nine months, the shortest period being two months, and the longest from two to three years.

The true pathology of these chronic abscesses is now conceded to be a tuberculous tumor with a softened centre, so that by simply opening and draining, the essential part of the disease remains untouched. The author has previously pointed out, in his lectures at the Royal College of Surgeons, three ways in which these abscess walls may be dealt with.

Excision. The most radical and satisfactory method is to dissect out the swelling without opening it, as if it were a cyst. This is applicable to many cases. For example, to many glandular abscesses, to the subcutaneous tuberculous nodules of children (gommes scrofuleuses), to many abscesses. Where this is done a clean-cut wound is left, which heals by first intention.

Piecemeal removal of the wall. If the abscess is too large, or its connections such that it cannot be dissected out in this way, the next best thing is to lay it freely open, so as to see its interior, and then remove the wall by clipping, cutting, etc. This is possible in a good many cases of abscesses in the extremities, and also elsewhere, and in this way we can generally get a healthy wound which heals by first intention.

Scraping. Either of these methods failing, we can still get rid of the greater part of the wall by making a smaller incision into the abscess, scraping away the wall with a Volkmann's spoon, or rubbing off the degenerating tissue by means of rough sponges, etc.

The way in which it has been carried out in most instances is, shortly, as follows: The necessary antiseptic precautions are, of course, taken, and a small incision is made into the abscess, somewhat larger than can admit the finger, which is then introduced and the cavity thoroughly explored. The surface of the abscess cavity is then gently scraped with a Volkmann's spoon, preferably a flushing-spoon, on the principle introduced by Mr. Barker, free exit being permitted to the fluid, and the finger being inserted from time to time to guide the spoon. Where the use of the spoon is dangerous—as toward the peritoneum or along a large vein, a good deal of the degenerating material can be removed by rubbing the surface with a piece of coarse sponge. If any loose pieces of bone is felt it should be removed, and the carious surface of the bone scraped if it can be got at. At the same time the cavity is thoroughly flushed out with warm (1:10,000) sublimate solution, and when it is thoroughly clean the fluid is squeezed out; one to two ounces of a 10 per cent. emulsion of iodoform in glycerin, containing a small proportion of bichloride of mercury, is introduced, and the external wound, and also the wound in the muscles, if present, is stitched up.

Of twenty-four cases treated in this manner, thirteen healed by first intention. They were sent out in a suitable apparatus, and with apparently no recurrence. Eleven of these remained well, but two came back some months later with sinuses. Of the remaining eleven cases the greater part of the wound healed by first intention in seven instances, small sinuses only remaining at some part. These were healed without difficulty by mild measures. Nineteen of the cases were thus cured, either at once or after a second operation. The best method of treating chronic abscess, namely, the complete removal of the disease by dissection, is applicable only in very rare instances. Practically, only in those in which the disease affects the posterior or lateral parts of the vertebræ.

THE ACCIDENTS WHICH MAY FOLLOW REMOVAL OF PORTIONS OF THE OMENTUM IN OPERATIONS FOR HERNIA.

BULL, under this heading, describes (*Annals of Surgery*, 1893, No. 3) some of the accidents which follow operations in which ligature of the omentum and excision are necessary.

The author has met with but a single case of hemorrhage from the omental stump, but he records a number of instances in which the stump became the seat of inflammation some time after the operation. Some of these cases underwent spontaneous resolution, while others went on to abscess formation, and thus demanded a second operation. The symptoms of the inflammatory process in the stump did not appear until from three to four weeks after the operation in the majority of the cases reported. The usual symptoms were a tender, immovable, and hard tumor, associated with local pain, rise of temperature, and vomiting. The author has invariably used silk ligatures in the past, but expresses his intention to return to the catgut ligature. He is inclined to look for the cause either in the ligatures used or some fault in the asepsis. A case is referred to in which death from perforative ulceration followed the inclusion of a small portion of the bowel wall in the omental ligature.

The article concludes as follows: In dealing with the omentum the following dangers are to be borne in mind: 1. Bleeding from inefficient ligature. 2. Damage to neighboring intestine from faulty application of the ligature. 3. Inflammation and abscess of the omental stump. These dangers should make the management of the omentum the subject of special care. Any threatened inflammation should be met by prompt excision as soon as symptoms are urgent.

GRADUAL AUTO-INOCULATION AS A FACTOR IN THE PRODUCTION OF IMMUNITY FROM SEPTIC INFECTION.

BINNIE calls attention (*Annals of Surgery*, 1893, No. 3) to the difference, in their clinical course, between those cases of appendicitis in which there has been perforation or gangrene of the process, and which run a rapidly fatal course, and the cases in which, after the existence of pyosalpinx for a long time, the tube suddenly ruptures and the fetid contents are poured out into the general peritoneal cavity. The latter almost invariably recover after simple excision and drainage.

This difference the author believes to be due to an acquired immunity in the latter affection, due to the presence of the pus in the body for a long time. The researches of Reichel seem to sustain this view. This author was able to produce immunity in animals against pyogenic micro-organisms by administering gradually increasing doses of pure cultures. Reichel reaches the following conclusion: "These experiments, in my opinion, undoubtedly prove that the immunity against the virus of pyogenic micrococci attained by the methods described is an immunity of the whole organism. In other words, that this immunity not only enables the nerve centres and the heart to withstand the noxious poison of infection, not only diminishes or destroys the susceptibility of the peritoneum to its irritation, but that it increases the power of every tissue, even of the subcutaneous fatty tissues, to resist the phlogogenic properties of the cocci.

The Treatment of Fractures of the Nose.

Walker Downie (*Glasgow Medical Journal*, 1893, No. 3) contributes an interesting article on fractures of the nose.

Although these injuries follow a variety of causes, the violence is always of a direct character. The nasal bones, from their prominent position, suffer most frequently from injuries of this region. The cartilaginous septum, in the author's experience, is seldom fractured, but is frequently dislocated. More rarely the lachrymal bone, the nasal process of the superior maxilla, the vomer, and the central plate of the ethmoid, may be involved. In all cases of fracture there is more or less laceration of the overlying mucous membrane, accompanied with more or less hemorrhage.

The amount of deformity will depend on the amount of swelling and ecchymosis which follows the injury. The septum may be considerably dislocated laterally without appreciably altering the contour of the nose.

When this structure is fractured, however, or dislocated backward, a characteristic depression will be seen immediately beyond the extremities of the nasal bones. The nasal bones themselves, when broken, may be displaced backward or to either side. If the lachrymal bones are implicated, emphysema of the eyelids and cellular tissue of the orbit is apt to follow.

The treatment of these cases should consist in arresting the hemorrhage, restoring the parts to their normal condition, and the application of proper means of retention. The bleeding is best controlled by plugging the nares, and as the posterior nares are never involved they need not be packed. After a single fracture the displacement does not tend to recur after the parts have been restored, but in the cases in which there has been comminution some means of retention after reduction is necessary. The method so often recommended, of plugging the nose after introducing a catheter, followed by the application of pads of lint applied to the nose externally and retained by adhesive plaster, is condemned, on account of being both unsurgical and disappointing in results.

The author prefers to use the leaden mask, in conjunction with intra-nasal splints made of the same material. After reduction the intra-nasal splint is applied. This somewhat resembles an almond in shape, and is furnished with a wing on either side at the broadest part. The flat portion lies in contact with the septal cartilage, and the curved wings lie against the inferior turbinated body.

The external splint is then fitted; it consists of a single piece of sheet lead, the nose-piece of which is prolonged over the alæ and on to the cheeks to give support; the upper part is continued on to the forehead. The whole is covered with a layer of silk or linen fabric fixed to its surface by means of paste. In dealing with old fractures the parts involved must be very thoroughly broken up, after which they can be moulded at will.

The intra-nasal splints may be removed at the end of four days, and the external splint in six days. Either, or both, may be reapplied if necessary. For controlling moderate hemorrhage, a 5 per cent. solution of antipyrine is recommended.

ENTERO-ANASTOMOSIS AS A SUBSTITUTE FOR CIRCULAR SUTURE.

BRAUN describes (in the *Archiv für klin. Chirurgie*, 1893, Bd. xxiv., Heft 2) his method of performing intestinal anastomosis. After resection of the bowel the two ends are inverted and a double row of sutures applied. The coils to be united are laid side by side, the closed ends pointing in opposite directions. This, the author considers a distinct advantage over Senn's method, in which the cut ends have the same direction, as, in the latter method, the peristaltic movements have a tendency to force the contents of the bowel against the sutured end. The slight torsion of the mesentery, which unavoidably occurs in Braun's operation, does not exert any unfavorable influence. After the ends of the bowel have been placed in their proper positions they are united by superficial sutures, which include the serous and a part of the muscular coat, the length corresponding to the length of the intended opening—5 to 9 centimetres. Care must be taken not to penetrate the lumen. The blind ends, which should be short, are secured to the adjacent intestine in order to prevent invagination. The next step is to make a cut 4 to 8 centimetres long through the serous and muscular coats down to the submucous coat. The cut is easily made, and permits of the passing of the silk sutures in the posterior margins of the incision with ease and safety. The mucous membrane is next incised, and the redundant edges are removed; the posterior margins, and then the anterior margins, are united with a continuous catgut suture. Finally, the anterior margins of the serous and muscular coats are united with a row of silk sutures, and a few stitches are passed at the extremities of the two rows of sutures.

The time required for the establishment of the actual fistula was from fifteen to twenty-five minutes, and the number of silk sutures employed varied from thirty-four to fifty-four. The author reports ten cases operated on by this method, with five recoveries and five deaths.

THE EXTIRPATION OF BRAIN TUMORS.

V. BRAMANN contributes a very interesting article on this subject in the *Archiv für klinische Chirurgie*, 1893, Bd. xlv., Heft 2. Two cases are reported. The first patient was a peasant, aged forty-six years. A year and a half previously to applying at the hospital he had received a blow on the head. He complained of headache; the left side of the face and left arm were paralyzed, and there was marked weakness of the muscles of the left leg. The reflexes of the affected side were exaggerated, and ankle clonus was present. Hearing and vision were impaired on the affected side. At this time the fundus of the eye appeared normal, although later choked disk of a light degree developed. The patient had frequent attacks of clonic spasms, beginning in the flexors of the left hand and ascending until the arm, shoulder, and left side of the face were involved. Consciousness was preserved during these attacks. During the spasm there was conjugate deviation of the eyes to the left.

The localized paralysis and spasms were thought to be due to a tumor of the brain, which was probably a large one, involving the posterior (movement of fingers) as well as the anterior central convolutions.

The convulsions gradually became more frequent, the pains in the head increased. On one occasion the patient had a syncopal attack, with nausea, vomiting, and slowing of the pulse. Operation was finally decided upon and performed after Wagner's method of temporary osteoplastic resection. The soft parts having been turned up as a tongue-shaped flap, the bone was chiselled through in the line of the incision in the soft parts, and its base broken by means of aspatories pushed along under the surface, and the flap laid back. After removal of the thickened dura, a cystic, fluctuating mass, feebly pulsating, was discovered. It was apparently distinct from the adjacent brain-substance, nevertheless a portion of the cerebral matter was removed as well as the growth. A drainage-tube was wrapped in iodoform gauze and inserted into the cavity, and an antiseptic dressing applied.

Although the wound healed satisfactorily, the patient was not benefited by the operation, and within two weeks convulsions similar to those before described returned. The drainage-track became surrounded by unhealthy granulations, and the part became prominent. The tumor was found to be a myxosarcoma, and the return of the convulsions was ascribed to a recurrence of the growth. A second operation was no more successful than the first. Finally, a third attempt was made to relieve the patient; this time a considerable portion of brain-substance surrounding the growth was removed. The cavity was four to six centimetres deep and as large round as a saucer. The result was eminently satisfactory. Two months after the last operation the patient was able to leave the bed, the choked disk had disappeared, power had returned in the paralyzed leg, the hand and forearm alone having failed to improve. A month later there were no signs of return of the disease. Sarcomata of the brain seem less prone to give metastasis than when these tumors are found in other portions of the body.

A second case was that of an artist who had received a blow on the right side of the head a year before coming to the hospital. At this time he had choked disks, most marked on the right side; diminution of the field of vision, particularly of the right; left-sided facial paralysis; paresis of left arm, and to a less extent of the left leg; also slight loss of power in the right leg. The reflexes were increased on both sides, but were most marked on the left. After being under observation for a week an edematous swelling appeared on the right side of the head. A few days later the patient had a convulsion affecting the left side of the face and the left arm and leg. The diagnosis lay between abscess and tumor. The choked disks, the absence of symptoms of meningeal irritation, of vomiting, of hebetude, of fever, and of anorexia favored the latter condition.

An operation was performed, when a neoplasm of the brain was removed which weighed two hundred and eighty grammes. A large part of the longitudinal fissure, and even the cribriform plate of the ethmoid bone, were exposed after the removal of the tumor. In order to equalize the intra-cranial pressure and prevent œdema of the brain, the cavity was firmly packed with sterilized iodoform gauze. Convalescence was tedious, but recovery finally took place. The choked disks disappeared, but the power in the limbs was only partially regained. The tumor proved to be a mixed spindle- and round-celled sarcoma.

The author devotes considerable space to a discussion of papillitis. This condition is almost invariably present in cerebellar tumors. Neoplasms in the frontal, parietal, and temporal regions cause a milder grade of the same condition. These variations are explained on anatomical grounds. The venous blood of the fundus is carried by the posterior and short ciliary veins directly into the cavernous sinus, or into the superior ophthalmic veins. The latter empty principally into the cavernous sinus; a portion of the blood, however, is delivered into the anterior facial vein. Any interference with the return circulation, either by pressure upon the vein accompanying the optic nerve or on the sinus itself, will give rise to a venous hyperæmia of the disk.

The sinus is so well protected in its membranous envelope that a great increase in the intra-cranial pressure, or a force acting almost perpendicularly from above downward, as a tumor of the base, is necessary to cause sufficient pressure to give rise to symptoms. An increase of pressure is noted much earlier, however, by the veins accompanying the optic nerve, which lack the complete protection of the dura, and, moreover, rest directly on the base of the skull. Hence, the choked disk in tumors of the cerebrum, especially in those situated near the convexity, is due primarily to compression of these veins; secondarily, to compression of the sinus. The stasis produced by even a remote tumor is naturally more intense the nearer the base of the brain the new growth is situated, and reaches its highest degree when a direct compression of the veins at their point of entrance into the sinus exists. Tumors in the median line, or very large growths, produce bilateral choked disk. In such cases the localization of the growth is very difficult, as the same condition is produced by cerebellar tumors. According to the author, an important point in the differential diagnosis is the presence of hemorrhage and ecchymoses in the retina and choroid. These are only met with in tumors near the base of the frontal lobe, and are never seen in cerebellar growths, no matter how advanced.

The author also offers an explanation of the choked disk occurring in tumors of the cerebellum, and in other affections of the posterior fossa of the skull. The blood from the orbit and bulb flows into the cavernous sinus, thence into the superior and inferior petrosal sinuses. The first, running along a groove in the petrous portion of the temporal bone, empties into the lateral sinus at a point where the latter emerges from the tentorium. The second flows backward toward the jugular foramen; a third, but inconstant channel, the basilar plexus of Virchow, carries the blood to the anterior spinal plexus. The inferior petrosal and the basilar plexuses lie in shallow bony grooves, and hence are easily compressible. The lateral sinus in that part of its extent occupying the sigmoid fossa of the temporal bone, is less resistant than the portion in the tentorium, which membrane separates more or less completely the posterior from the middle and anterior fossæ of the skull. A tumor or an abscess developing beneath the tentorium, even if small, will produce a more marked increase of pressure than similar affections of the hemisphere. This rise of pressure extends to the brain and its membrane, to the lateral sinus, as well as the other two feebly protected channels. The first result is a stasis in the cavernous sinus, which soon leads to stagnation in the fundus. Tumors of the occipital lobes, by downward pressure on the tentorium, also produce choked disk—as in nearly all cases of tumors of the hemispheres, more marked on one side. Affections of the temporal lobes are very variable in respect to the production of choked disk, and it has been generally supposed that this condition is very rare. Excluding the more common disease of this region—namely, abscess following middle-ear disease —we will find that choked disk is by no means rare, but is not as marked as would be expected from the proximity to the cavernous sinus. The explanation of this condition is found in the fact that the cavernous sinus is exceedingly well protected against lateral pressure both by the enclosing dura and more efficiently by the processes of the tentorium attached to the anterior and posterior clinoidal prominences. The more anterior a tumor of the temporal region is situated, the more marked will be the difference in the stasis in the two eyes. If the tumor is located at the base of the third frontal convolution, compressing the optic tract and its vessels, then we shall have choked disk of the corresponding eye only. It is a fact that the degree of the choked disk does not depend so much upon the size of the tumor as upon its structure and mode of growth. Circumscribed tumors produce more marked symptoms than abscesses and diffused growths, which form at the expense of the brain mass.

In regard to the technique of cerebral surgery the author dwells upon the importance of checking all hemorrhage. Compression with sterile gauze during the operation, and with an iodoform tampon afterward, is of the utmost importance in preventing œdema. Large cavities should not be packed with iodoform gauze exclusively, as there is danger of intoxication. Opening of the skull simply to relieve pressure is condemned by the author.

PERFORATING CARCINOMA OF THE SCALP.

BRAUN (*Archiv für klin. Chir.*, 1892, Bd. xlv., Heft 1) reports a case of cancer of the scalp, originating from scar tissue, in a child twelve years old, and growing rapidly until the fourteenth year, when it came under his observation. It was then ulcerated and pulsating. He decided to remove it in successive operations, disinfecting the wound as much as possible before removing the inner portion of the growth, and waiting to close the external wound until the inner portion had healed without any sign of return *in situ*. The operation showed that the growth involved not only the skin, but the bone, dura and pia mater, and the brain-substance itself. These diseased portions were removed in the successive operations, fine needles with catgut sutures being passed under the arteries of the pia mater and then the ligatures tied, while the diseased portion of the brain substance was removed by the knife or the actual cautery. After the removal of one return of disease *in situ*, the wound was closed by an osteo-plastic operation, six months after the last sign of recurrence. The patient made a complete recovery with no symptoms of further disease.

CHOLEDOCHOSTOMY.

TERRIER (*Rev. de Chir.*, Fév. 1893), after defining this operation as the permanent opening of the ductus choledochus, gives a critical and detailed study of the only four cases which have been operated upon. None of these were premeditated operations, nor was the true nature of the tumor diagnosed, except in one case, before the autopsy, and in this case the report is so meagre that it is impossible to determine the surgeon's reason for the establishment of the fistula, or the condition found present in the choledochus. The author concludes from the cases studied, that the enormous dilatation of the ductus choledochus appears to accompany frequently the infection of the biliary passages, which complicates in all cases any operation and renders it very grave. As a consequence of the rarity of cases in which this operation is justified and in which it has been performed, it is impossible to formulate rules of procedure until other observations, with the results of intervention, have been published.

THE TREATMENT OF TUBERCULOUS JOINTS WITH IODOFORM OIL.

THE *Centralblatt für Chirurgie*, 1893, No. 3, reviews the monograph of DE VOS on this subject. The work embraces the results obtained at the clinic and polyclinic at Leyden, covering a period of a year and a half. The iodoform was prepared in the following manner: Ten grammes of the powder were placed in a black glass bottle and covered with a solution of corrosive sublimate 1 : 1000, which was allowed to remain four days; the fluid was then decanted and the iodoform washed repeatedly with fresh distilled and boiled water; to this aseptic iodoform was added 100 grammes of olive oil which had been previously boiled ten minutes and cooled down to 30° C., and repeatedly shaken.

For injections into the hip-joint the author recommends that the needle should be fourteen centimetres long; when the injection is made into bone the needle is provided with a stylet. After experimenting on cadavers the author recommends the following methods for injecting the different joints. For the shoulder-joint: adduction of the arm, with the forearm bent at a right angle across the body; the needle is entered one centimetre behind and below the point of the acromion. For the elbow: a point is selected external to the olecranon, the needle being entered between the head and tuberosity of the radius. The wrist: the point of election is, on the radial side, the most dorsal corner of the tabatière; on the ulnar side, a place on the upper anterior course of the pisiform bone. For the hip, the author's method is as follows: the mid-point between the anterior superior spine of the ilium and the tuberosity of the pubes is designated; from a point the breadth of the patient's thumb external to this a line is drawn downward to the external point of the trochanter major; this last line is divided into four equal parts; the first dividing-point from the trochanter is the point at which the needle is to be entered. It is necessary that the limb should be straight and the inner border of the foot should be vertical. If the position of the trochanter is out of the Roser-Nélaton line the needle must be carried a corresponding distance in the same direction. For the knee: at the point between the upper end of the tibia and the ligamentum patellæ. For the ankle: on the outside of the foot closely anterior to the point of the malleolus in a direction toward the calcaneum.

It is recommended to make the injections slowly, occupying about ten minutes for the introduction of 10 grammes. For adults, 1 gramme of iodoform may be used with safety. If no reaction appears, the second injection is to be made in eight days. The intervals may gradually be made longer.

Massage and passive movements are not to be used after the injections, as this might produce iodoform intoxication or disseminate the tubercular infection. Moderate active movements are recommended. Some of the symptoms of iodoform intoxication are dimness of vision, retinal hemorrhages, and a papular retinitis. The author considers iodoform oil better than the glycerin mixture for theoretical reasons. Of the cases reported, the duration of treatment varied between 9 and 325 days; the number of injections from one to twenty; the amount of iodoform used in a case from 2 to 67½ grammes; the amount of oil used from 10 to 385 grammes. Result, 72 per cent. entirely cured. Of the 68 cases, 60 were clearly joint tuberculosis. Only 2 cases of recurrence were observed.

DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

UNDER THE CHARGE OF

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Œsophagoscopy.

Dr. Ludwig Löwe, of Berlin, describes (*Deutsche med. Wochenschr.*, 1893, No. 12) a method of œsophagoscopy which he has devised, differing from the various methods practised by Semeleder, Stoerk, Waldenberg, Morell Mackenzie, and Mikulicz. The œsophagoscope and the images rendered are illustrated by cuts, to which the reader must be referred for intelligible details.

Abscess at the Base of the Tongue.

An instance of this rare lesion is reported (*Annales des Mal. de l'Oreille, etc.*, 1892, No. 12) by L. Hélary from the service of Prof. Gouguenheim.